MARYLAND MEDICAID PHARMACY PROGRAM
TEL: 1-855-283-0876
FAX: 1-866-671-8084

REQUEST TO AUTHORIZE ANTIPSYCHOTIC PRESCRIPTION CHILDREN UNDER FIVE YEARS OF AGE

Incomplete forms will be returned.

PRESCRIBER INFORMATION

Name:_____ _____ ___ NPI#_____ Med. Specialty:_____
(Last) *(First)* *(MI)*

Tel:_____ Alt. Tel:_____ Fax:_____ Email Address:_____

Mailing Address:_____

PRESCRIBER DELEGATE FOR FUTURE CONTACT (IF APPLICABLE)

Name:_____ _____ Tel:_____ Alt. Tel:_____ Fax:_____
(Last) *(First)*

Email:_____ Mailing Address:_____

PATIENT INFORMATION

Name:_____ _____ ___ MA#_____ DOB:_____ ☐ F ☐ M
(Last) *(First)* *(MI)*

Mailing Address:_____ Tel:_____

CLINICAL INFORMATION AND LABORATORY VALUES

Height _____ in. Weight _____ lbs.

ECG required only for quetiapine and ziprasidone

Last ECG: Test Date_____ Results: ☐ normal ☐ abnormal Prolonged QT/QTc: ☐ absent ☐ present

Fasting Glucose: Test Date_____ Fasting Glucose Value_____

Lipids: Test Date_____ __ LDL Value _____ HDL Value _____ Fasting Tryglicerides Value_____

Hepatic Function: Test Date_____ AST Value_____ ALT Value_____ Alkaline Phosphate Value_____

Abnormal Involuntary Movement Scale (AIMS): Exam Date_____ AIMS Score_____

Diagnoses: _____

TARGET SYMPTOMS

Check all target symptoms for which drug is being prescribed

☐ irritability ☐ mood instability ☐ aggression ☐ depression ☐ hyperactivity ☐ self-injurious behavior

☐ anxiety ☐ sleep disturbance ☐ impulsivity ☐ hallucinations ☐ delusions ☐ other (please list)

_____

CRISIS INTERVENTION/ HOSPITALIZATION

Has patient been hospitalized or received emergency or crisis intervention services within the last 30 days? ☐Yes ☐No

Date Admitted_____ Date Discharged_____ Institution/Agency_____

Type of Service:

☐ general hospital admission ☐ emergency room visit ☐ psychiatric hospital admission ☐ crisis intervention

☐ other (please explain)_____

Chief Complaint_____

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NON-PHARMACOLOGIC TREATMENT

Is the patient currently receiving non-pharmacologic treatment or receiving psychosocial evaluation? ☐Yes ☐No ☐Pending

If pending, when is scheduled appointment date? _____

Type of non-pharmacologic therapy or evaluation:

☐ Local Health Department ☐ Department of Social Services ☐ Department of Juvenile Services ☐ Psychiatric services

☐ Independent clinician ☐ School-based program ☐ Headstart ☐Other (please specify)_____

PHARMACOTHERAPY

Antipsychotic for which authorization is being sought:

☐ aripiprazole ☐ clozapine ☐ iloperidone ☐ olanzapine ☐ pimozide ☐ thioridazine

☐ asenapine ☐ fluphenazine ☐ loxapine ☐ paliperidone ☐ quetiapine ☐ thiothixene

☐ chlorpromazine ☐ haloperidol ☐ lurasidone ☐ perphenazine ☐ risperidone ☐ trifluoperazine ☐ ziprasidone

Dosage strength (mg): _____ Regimen:_____ Total Target Daily Dose (mg):_____

Is patient currently receiving another antipsychotic? ☐Yes ☐No **If yes, check all that apply:**

☐ aripiprazole ☐ clozapine ☐ iloperidone ☐ olanzapine ☐ pimozide ☐ thioridazine

☐ asenapine ☐ fluphenazine ☐ loxapine ☐ paliperidone ☐ quetiapine ☐ thiothixene

☐ chlorpromazine ☐ haloperidol ☐ lurasidone ☐ perphenazine ☐ risperidone ☐ trifluoperazine ☐ ziprasidone

Dosage strength (mg): _____ Regimen:_____ Total Target Daily Dose (mg):_____

Is there a plan to taper or discontinue the current antipsychotic(s)? ☐Yes ☐No

Please list if more than one: _____ _____ _____

Is the patient currently receiving other psychotropic agents including medications for side effects? ☐Yes ☐No

If so, please list them below and indicate whether the intent is to continue or discontinue them:

Medication:_____ Dose:_____ Regimen:_____ ☐Continue ☐Taper to discontinue ☐Discontinue

Medication:_____ Dose:_____ Regimen:_____ ☐Continue ☐Taper to discontinue ☐Discontinue

Medication:_____ Dose:_____ Regimen:_____ ☐Continue ☐Taper to discontinue ☐Discontinue

Medication:_____ Dose:_____ Regimen:_____ ☐Continue ☐Taper to discontinue ☐Discontinue

Medication:_____ Dose:_____ Regimen:_____ ☐Continue ☐Taper to discontinue ☐Discontinue

Medication:_____ Dose:_____ Regimen:_____ ☐Continue ☐Taper to discontinue ☐Discontinue